OFFICE OF THE INSPECTOR GENERAL FOR MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Primary Inspection
Southern Virginia Mental Health Institute

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Inspector General

Report #108-05

SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
DANVILLE, VIRGINIA
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OIG Report #108-05

INTRODUCTION: The Office of the Inspector General (OIG) conducted a primary inspection at Southern Virginia Mental Health Institute (SVMHI) in Danville, Virginia during December 13-14, 2004. The inspection focused on a review of the facility through the application of 19 quality statements. These statements are grouped into 6 domains that include facility management, access to services, service provision, discharge, quality of the environment, and quality and accountability. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the mental health facility directors, consumers, Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) central office administrative staff, DMHMRSAS Office of Mental Health Services staff and directors of mental health services for community services boards (CSB). The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. The report is divided into sections that focus on each of the domains previously noted.

SOURCES OF INFORMATION: Interviews were conducted with 34 members of the staff including administrative, clinical and direct care staff. Interviews were also completed with 12 consumers. Documentation reviewed included, but was not limited to, 4 clinical records, selected policies and procedures, staff training curricula, facility quality management plans, and risk management reviews. Tours of the facility were conducted.

BACKGROUND: SVMHI is one of seven mental health facilities operated by DMHMRSAS that provide services to adults. The facility's operating capacity was reported to be 72 beds. At the time of the inspection, the facility had a census of 76, which is slightly above the reported capacity but well within its authorized capacity of 96 beds. SVMHI serves three community services boards.

The approved budget for this facility in FY 2004 was $10,073,765 with reported expenses for the same period of $10,073,729. Information provided by the facility during the inspection indicated that the budget for FY 2005 is $9,652,923. This represents a decrease in funding from the actual expenses of the previous fiscal year of $420,806. The facility reported that the cost per bed day at the time of the inspection was $444.27.

MENTAL HEALTH FACILITY QUALITY STATEMENTS

Facility Management

1. The facility has a mission statement and identified organizational values that are understood by staff.

The mission statement for SVMHI is as follows:

> *As an institution of the Commonwealth, our charge is to clinically treat those human beings placed in our care, insuring their rights are protected while holding them responsible for their actions in order that they can begin the journey to the community of their choice.*

The mission statement was revised in 2003 to emphasize the importance of consumers actively participating in their own treatment process and sharing responsibility for their outcome. Interviews with administrative, clinical and direct care staff reflected a good working knowledge of the facility's mission. Eight of the 9 direct care staff members interviewed indicated that a part of the mission of the facility is to assist consumers in successfully reintegrating into the community. The majority of those interviewed stated also that the facility strives to provide quality services to patients in the least restrictive manner.

The majority of direct care staff interviewed had some difficulty defining the values that govern the work of the facility. The values as described by administrative staff were comparable to those identified in the SVMHI Patient and Family Guide. These included: treating all persons with dignity and respect, placing the consumers first, being responsive to patients, exhibiting compassion, maintaining confidentiality and providing of services in a safe environment.

2. The facility has a strategic plan.

Interviews with administrative staff members revealed that the facility has a strategic plan. In addition to this plan SVMHI has been working collaboratively with a regional partnership group, the Southside Behavioral Health Consortium to accomplish strategic initiatives that will be beneficial to the entire region. This group includes, but is not limited to, representatives of the facility, the community services boards, local hospitals and consumers. The Southside Behavioral Health Consortium meets regularly to evaluate the initiatives already established and to facilitate additional restructuring of services within the community to more effectively address the needs of those served. One of the elements highlighted in both the Consortium's utilization management plan and the facility's strategic plan is to work toward meeting the acute care needs of the citizens in the catchment area at the local hospitals and utilize the facility to serve persons with more intermediate or intensive needs who will benefit from a more concentrated program of services such as psychosocial rehabilitation programming.

Administrative staff indicated that as a result of a recent employee survey, facility leadership has become increasingly aware of the staffs' need to understand both the short-term and long-range goals for the facility. Staff has expressed an interest in being active participants in the development of the facility's future plans.

3. The mission and strategic plan have been reviewed and are linked to the recently adopted DMHMRSAS Vision Statement.

Administrative staff interviewed indicated that the facility has not completed a formal review of its mission and strategic plan in conjunction with the DMHMRSAS vision statement. They did, however, point out that the work both within the consortium and the facility emphasizes the development of a community-based system of care that supports the recovery and empowerment of consumers.

4. There are systems in place to monitor the effectiveness and efficiency of the facility.

Interviews revealed that the facility has a number of systems in place to monitor its effectiveness. Outcome measures have been established and are reviewed by the facility's leadership team and by the various disciplines. The facility monitors data in such areas as the number of falls, the use of seclusion and restraints or other restrictive procedures, the number of consumers that require the use of 1:1 staffing, the number of times emergency medications and PRN medications are used, and the length of stay of the consumers. Interviews revealed that the data in each of these areas provides the facility with useful information for determining the effectiveness of services and interventions. During the past year, the facility installed a Docu-med system. The use of this system allows for improved monitoring of medication usage and safer dispensing practices. Among the process improvement initiatives targeted for implementation during 2005 are streamlining the treatment planning process to facilitate documentation of the outcome of patient treatment and a falls reduction program.

Interviews with the leadership of several clinical disciplines revealed that each uses outcomes measures to determine the effectiveness of the work completed. Methods included documentation checks, peer reviews of assessments and recommendations, and the degree of staff involvement in team meetings.

One method used by the facility to determine the effectiveness of the services provided is to conduct a consumer satisfaction survey. Consumers respond to questions regarding human rights, outcomes of treatment, the environment of care, staffing and treatment with dignity and respect. Staff reported that the survey allows the facility to benchmark with other facilities in-state and nation-wide that serve similar populations. In addition, the facility reviews data regarding recidivism and the successful completion of individualized goals on consumers' treatment plans.

Interviews with administrative staff indicated that the facility has increased its ability to more readily monitor its effectiveness in recent years. Staff stated that there continues to be a need for the development of measures and initiatives to monitor efficiency.

5. There are systems in place to assure that there is a sufficient number of qualified staff.

Data provided by the facility indicated that SVMHI has 175.5 approved full-time employee positions, 162 of which were filled at the time of the inspection. Of these 175.5 full-time positions, there were 42.5 Direct Service Associate (DSA) II positions and 43.5 nursing positions, including supervisory staff. It was reported that SVMHI has elected to unfund the following positions due to budget constraints:1 FTE Physician, 1 FTE PC Support Technician, 5 FTE DSAII and 2 FTE Nursing Unit Secretaries. This leaves the facility with a staffing complement of 166.50.

SVMHI staffing includes the following numbers of clinical staff:

- 4 FT physicians and 1 FT nurse practitioner. In addition, there is a contract Medical Director for15 hours per week.
- 6 FT psychologists, including the director. At the time of the inspection, one psychologist was on extended medical leave.
- 8 FT social workers, including the director.
- 6 FT activity therapists, including the supervisor. The Director position has a dual function and allots only 50% time to activity therapy.
- 1 FT pharmacy supervisor and 1 FT pharmacy assistant.
- 1 Director of Community & Clinical Services Development.

The direct care positions, human service care workers and nurses, have traditionally been the positions that are the hardest to fill. The facility reported that the average salary for the recently hired registered nurse positions was $42,000 and for the direct care staff, approximately $18,000. Seven of the 13.5 vacant positions at the time of the inspection included 1.5 registered nurse positions and 5.5 direct care staff positions. Two important challenges for the facility are attracting qualified applicants and retaining staff. By conducting a staff communication survey, facility leadership was provided with feedback that can be used to enhance staff satisfaction, which ultimately impacts retention. Several initiatives for enhancing staff satisfaction are currently under review. One of these deals with increased communication.

All staff receive orientation and training specific to their positions within the facility. Direct care staff are involved in a four-week intensive training program that includes on-going review of their knowledge and skill by their supervisor. Staff must be able to demonstrate competency.

Interviews revealed that the facility has to rely on the use of overtime in order to assure there are sufficient numbers of nursing and direct care staff available on each shift. It was reported that the facility spent approximately $400,000 during the past fiscal year in

overtime, averaging 2400 hours of overtime each month. During the tours of the units, one staff member was on overtime.

Staffing numbers for December 13, 2004 as provided by the facility and census at the time of observation on first shift were as follows:

Unit E: Days 5 / Evening 4 / Night 3 – census of 13 with one additional person out on special hospitalization.
Unit F: Days 7 / Evening 5 / Night 4 – census of 20 consumers with one additional person out of facility on pass. One patient required 1:1 supervision.
Unit G: Days 5 / Evening 4.5 / Night 3 – census of 18 consumers with two additional individuals out on special hospitalization.
Unit H: Days 6 / Evening 5 / Night 3 – census of 17 with one additional person out of facility on pass.

On the dates of the inspection, the facility data indicated that there were 12 patients on special checks. These patients are free to roam throughout the building but staff must eyeball them and document the observations. Also, 7 patients were transported for medical consults on December 14, 2004, which requires at least 2 staff members designated to assist for each trip.

The facility uses staff as hall monitors when a consumer is on unit restriction. The monitor is placed in the area between two adjoining hallways in order to observe the movement of the consumers. There were two hall monitors stationed during the evening shift.

6. There are mechanisms for direct care staff and clinical staff to participate in decision-making and planning activities.

Eight of the nine direct care staff members interviewed indicated that there are mechanisms for staff participation in facility decision making and planning activities. They mentioned team meetings, supervisory contacts and an anonymous suggestion box as avenues they could use to communicate concerns or make recommendations. In addition, those interviewed reported that staff are provided with opportunities to participate on various committees within the facility. They also mentioned that the facility director has an open door policy and is willing to listen directly to staff concerns and/or suggestions.

As mentioned above, SVMHI conducted a staff communication survey in August 2004. The survey aided the leadership in gauging the effectiveness of communication strategies within the facility among the staff. It was generally reported that leadership initiatives are usually communicated to the direct care staff through the chain of command. Through the survey, staff indicated that they wanted more information regarding any proposed changes to the mission of the facility so that they can be actively involved. Administrative staff indicated that the leadership team is developing several strategies for enhancing communication within the facility.

7. Facility leadership has a plan for creating an environment of care that values employees and assures that treatment of consumers is consistent with organizational values.

No specific plan for creating an environment of care that values employees is in place. Interviews with staff on all levels indicated that there are a number of ways in which the facility works to demonstrate to staff that they are valued. All of the direct care staff interviewed felt valued. Most cited the recent re-instatement of a small cash reward system as a simple gesture of appreciation. These rewards are offered to staff who suggest good strategies for improving services.

The facility uses the employee monthly newsletter to reinforce the philosophy of working with consumers regarding the principles of self-determination, empowerment, and recovery through the question and answer section, the Director's corner, and synopses of the Management Team meeting minutes. The facility plans to initiate monthly staff meetings with the Director and other Administrative Team members to reaffirm the corporate values and answer questions about the direction the facility is going. In addition, the Administrator-on-Call is completing tours of the facility during all shifts to engage staff in discussions around the facility's vision and mission. A committee will review and approve PSR programming to insure that the groups promote the SVMHI treatment values.

During the visit the OIG staff observed an incident that indicated that staff need additional training regarding how to relate to consumers. A newly admitted consumer entered the nursing station on Unit E. He sat down in a chair in that room. When one staff member informed the person that he could not be in the office, he refused to move. Staff proceeded to force the patient to move by pulling both the patient and the chair into the hallway. In the process, the patient fell to the floor. The consumer returned to the chair in the office. The staff then gave conflicting instructions to the consumer – stay and move. After a period of confusion, one staff member physically removed the consumer from the office. The consumer remained confused, and there was no further attempt on the part of staff to work with the individual

Access

1. There are systems in place to assure that those admitted to the facility are appropriate.

SVMHI serves adults between the ages of 18 and 64, who reside within the catchment area served by The Danville-Pittsylvania Community Services Board, Piedmont Regional Community Services Board, Southside Community Services Board and Charlotte County. The facility policy that governs admissions indicates that the facility admits persons whose "mental status and accompanying behavior pose significant threat of harm to self or to others" and when there are no community-based alternatives available to provide the level of safety and care required.

Data provided by the facility reported that there were 466 admissions to the facility during calendar year 2004. Of those, 280 admissions were male and 186 were female. It was reported that the facility received 500 requests for admission during the same time period.

The 3 primary reasons that admission to the facility was denied included:

- The applicant had a primary substance abuse issue with no substantial risk to self or others.
- The applicant had a primary medical problem necessitating medical inpatient care.
- The applicant was a consumer who resides within the service area of a different state facility for which involuntary commitment was sought.

A prescreener from the appropriate community services board conducts an assessment of each person considered for admission. Interviews with administrative staff revealed that it is the facility's practice to accept those individuals assessed to be appropriate by the community-based prescreener.

One of the outcomes of the ongoing meetings of the Southside Behavioral Health Consortium has been a regional agreement which establishes the optimum treatment setting for patients. In general, persons in need of acute hospitalization are referred for care to the two local private hospitals, while those in need of more intensive or longer term care are referred to SVMHI.

2. The facility works collaboratively with CSBs to assure access to appropriate services when admissions to the facility are inappropriate or not possible due to census.

Administrative staff reported that the facility does not deny admissions on the basis of census. The regional planning group has made it a priority to insure census is not a reason for denying an admission. First, CSBs try multiple placements before turning to SVMHI for a bed. The recent bed diversion funding the region received from DMHMRSAS has shown to be an effective tool in securing an appropriate inpatient placement for the consumer in the community. When a community prescreener refers for admission to SVMHI, it is assumed that all other alternatives have been explored and the consumer is admitted. The following business day, the case is reviewed for appropriateness. If the case is determined to be inappropriate, SVMHI's clinical coordinator contacts the CSB Mental Health Director to begin the development of a plan for an appropriate transfer or discharge. Regionally, these types of cases are presented to the utilization review committee. They are discussed in the aggregate and resolutions to placement issues are explored.

Service Provision

1. There are systems in place to assure that the patient receives those services that are linked to his/her treatment needs and identified barriers to discharge.

Each person admitted to the facility undergoes a series of assessments with a number of disciplines. A nursing screening of both medical and psychiatric risks factors occurs within the first half-hour of the admission process. A complete physical examination and psychiatric evaluation are completed within the first 24-hours. The majority of assessments are to be conducted prior to the formal treatment planning session, which occurs within seven days of admission. These assessments become the basis for developing the individualized treatment plan. Interviews with clinical staff indicated that treatment objectives are prioritized with a focus on those objectives that are related to "barriers" to the person re-entering the community.

Of the 72 patients at the facility on the first day of the inspection, 45 or 63% had a primary diagnosis of schizophrenia or other psychotic disorder. The remaining patients were diagnosed as follows:

- 10 patients had a primary diagnosis of a mood disorder
- 9 had a primary diagnosis of a substance related disorder
- 1 had a primary diagnosis of substance induced psychosis
- 3 had a primary diagnosis of a personality disorder
- 2 had a primary diagnosis of an amnestic disorder
- 1 had a primary diagnosis of a delusional disorder
- 1 had a primary diagnosis of mental retardation.

Consumers are actively engaged in identifying treatment needs during the treatment planning process. SVMHI operates a psychosocial rehabilitation program (PSR) designed to provide didactic and experiential opportunities for consumers in order to address those issues that impact each person's ability to successfully reside in the community. Group activities are offered from 9:00 am until 4:15 pm, Monday through Friday. There are also leisure activities scheduled during the evening and weekends.

During the inspection, the OIG observed three sessions. These included symptom management, medication management, and anger/conflict management. The symptom management group was late getting started because the regular instructor could not be present and another staff member was filling in. The group completed a lesson called "Understanding Your Illness" and discussed activities they could engage in to feel relaxed and manage stress. The instructor actively engaged the participants.

The medication management class was cancelled. Interviews revealed that the session was not held because consumers did not show up. The conflict/anger management group began on time. There were 10 participants in the beginning of the group but only 5 persons remaining at its conclusion. The instructor led the group in discussing the best way to deal with rage and methods for making appropriate decisions about how to handle

difficult circumstances. The leader also discussed "primitive brain vs. new brain" and how to retrain your brain to process your thoughts through the "new brain". There seemed to be some confusion regarding this topic but participants who remained appeared actively engaged in trying to process the information.

Three of the 12 consumers interviewed indicated that the groups were the most helpful aspect of their hospitalization. During the past year, the PSR team has been working to refine the groups to assure that they are designed to meet the needs of the consumers served. The team has visited other state-operated mental health facilities to understand "best practices" across the mental health system.

2. There are processes in place that support evidence-based practices.

Interviews indicated that the facility attempts to stay abreast of best practices through participation in satellite training programs and other training opportunities. It was reported that Central Office staff are a valuable resource for the facility in obtaining information regarding evidence-based practices. Practices such as medication education, symptom management and recovery skills are key components of the psychosocial rehabilitation programming. Even though the facility has several processes in place to support evidence-based practices, staff of all disciplines indicated that increased efforts are needed in this area.

3. The facility assures that service provision is grounded in the principles of recovery, self-determination and empowerment.

Those interviewed stated that the facility is actively seeking to incorporate recovery principles in all aspects of each person's care and treatment. The following comments were shared to explain how this is occurring. They talked about the importance that is placed on consumers entering into a partnership with the facility. The partnership includes the expectation that as a person becomes stable they become increasingly responsible for the direction and outcome of the treatment process. Direct care staff stated that the use of recovery principles is most fully realized for consumers in the PSR program and through their involvement with their treatment teams. Finally some said that community meetings and patient forums are held in order to provide consumers with an avenue for making suggestions regarding the environment of care and treatment. Staff did not talk about the importance of the nature of the relationship between the staff and the consumers.

4.There are systems in place to measure the perceptions of consumers, families, direct care staff, clinical staff and administrative staff regarding the quality of the provision of care and services.

There are formal and informal mechanisms at SVMHI for measuring the perceptions of the consumers, their families and staff regarding the quality of the care and services provided. Community meetings, staff's informal interactions with patients, and consumer satisfaction surveys are among the mechanisms identified during interviews.

As appropriate, families and/or the consumers' legally authorized representatives (LAR) are encouraged to participate in the treatment and discharge planning. Feedback is elicited during routine contact by the social workers.

Staff perceptions are measured in supervisory meetings, team meetings, formal satisfaction surveys and through other mechanisms such as a suggestion box and direct access to the facility director.

Discharge

1. There are systems in place for effective utilization review and management.

Utilization review (UR) and management occur both within the context of the Southside Behavioral Health Consortium and the SVMHI UR Committee. The consortium review team is comprised of the mental health directors from the three community services boards and the SVMHI Director of Community and Clinical Services Development. The internal review committee includes the facility medical director, a UR physician and the UR coordinator.

There are three area of focus for utilization review. These include the management of admissions to and bed day purchases from private psychiatric providers, the management of admissions and discharges at SVMHI, and the clinical and utilization management of each consumer's course of treatment.

The group plans to begin monitoring data pertinent to utilization management within the region such as recidivism rates to any facility within 30 days of discharge and the length of stay for consumers both in the private and state programs.

2. There are systems in place to assure that effective communication occurs between the patient, facility and community liaisons regarding discharge readiness in order to assure a smooth transition of the patient into the community and to prevent re-hospitalization.

Social workers serve as the primary point of contact between the facility, the consumers, the LAR and the community. Interviews revealed that social workers from the facility maintain weekly contact with community liaisons to discuss cases and to review discharge readiness and plans. Information from these meetings is communicated to all parties involved including the consumer and potential treatment providers. Family members (as appropriate), LAR, and community liaisons are invited to participate in regularly scheduled treatment planning meetings during which discharge readiness and plans are explored. Contact increases as the time of discharge gets closer. It is the primary responsibility of the facility in partnership with the consumer and/or the LAR to determine the needs of the consumer upon discharge. This information is communicated to the community liaison, whose responsibility it is to facilitate arrangements for service provision, housing and other identified service needs. The liaison also helps to make appointments with community providers. Crisis plans are developed for those persons

identified as high risk for re-hospitalization because of past history. Crisis plans are developed with the involvement of the consumer to determine strategies for securing supportive services within the community in the event of a situation that challenges that person's ability to safely remain in the community. Interviews revealed that effective discharge planning and established community linkages are the best mechanisms for preventing re-hospitalization.

Quality of the Environment

1. The physical environment is suitable to meet the individualized residential and treatment needs of the patients and is well maintained.

Observations were made on all four residential units during the two-day unannounced inspection. Thirteen patients and ten direct care staff were interviewed. The staff members included both human service care workers and nursing staff members. Overall, OIG staff was on the units for approximately 11 hours, spanning two shifts, providing opportunities for informal interactions.

The four residential units at SVMHI included E, F, G and H. All the residential units are co-ed. Only H Unit is specifically designated for treatment of the specialized forensic population.

Observations of E Unit demonstrated that overall the environment was clean, well maintained and odor free. The men's bathroom was dirty with trash and towels but was cleaned while staff was on site. It is important to note that at this facility, there is not a men and women's bathroom on each unit. There is a men's bathroom on Unit H and the female bathroom on F Unit. Even though the consumers are aware of the appropriate bathroom to use, this arrangement is less than suitable particularly for individuals that are unstable. Interviews revealed that during the day when the seclusion room is not in use, the seclusion room bathroom is used to accommodate the patients that do not have a designated bathroom on that unit. The common room was decorated for the holidays with a tree, figurines, bows, and garland. There was a bulletin board with a movie night list posted and other general information that could be of interest to the patients. The patients on the unit at the time of the observations were drinking coffee, watching TV, sleeping, looking out the window, in their rooms, or walking around.

Observations of F Unit revealed that the unit was generally clean with no odor except for the common room where both the floor and the coffee table were dirty. The common room was decorated with a tree. The visit on this unit occurred during group time so many of the patients were in the PSR program. Those that were on the unit were watching TV, listening to music, reading, walking or in their rooms. The unit has a seclusion room, but it was not being used.

On G Unit it was observed that the bathroom was clean with no odor, and there was no odor on the unit. The common room floor and table were dirty. There was a tree and other Christmas decorations in the room. An information board was posted and pictures

were hung on the walls. The visit occurred during group time so many of the patients were in the PSR program. Those that were on the unit were watching TV, attending to their activities of daily living (ADLs), reading, walking or in their rooms. The unit has a seclusion room, but it was not being used.

Observations on H Unit revealed that for the most part the unit was clean and odor free. Trash and used towels were on the bathroom floor. A Christmas tree, wreath and other Christmas decorations were noted in the common room making the area appear festive. The visit on this unit occurred during group time so many of the patients were in the PSR program. Those that were on the unit were watching TV, reading, walking, sleeping or in their rooms. The unit has a seclusion room, but the OIG was informed that it was being used as a regular patient room because of the census. It was explained that if the unit needed to use a seclusion room, they would use the room on unit G.

The OIG also observed lunchtime activities. This meal is served over the course of an hour. The patients that have special diets go first. They retrieve a card at the entrance to the cafeteria that is given to the cafeteria worker so that the correct diet is provided. The food is prepared daily as the facility does not use the cook/chill system utilized at most of the facilities. The food looked appetizing. There were a variety of foods served from which patients could choose.

There are hand sanitizers on the wall as you enter and exit to control the spread of infections. The windows were open despite the "keep windows closed, no fly zone" sign primarily because the weather was unseasonably warm. The dining room was clean. There was "easy listening music" playing and holiday decorations were noted. It was noted that patients were served throughout the hour. There were four staff members monitoring the dining area.

Five of the twelve consumers interviewed indicated that the food was the best thing at the facility, however they did qualify their statement by indicating that they did not feel they received adequate portions. One patient interviewed said she felt hungry most of the time.

The facility identified the following as its three most critical capital improvement projects:

- To provide male and female bathrooms on each of the four units
- To complete needed repairs and/or replacement of the asphalt in the parking lots and driveways.
- To replace HVAC controls in order to assist with energy management

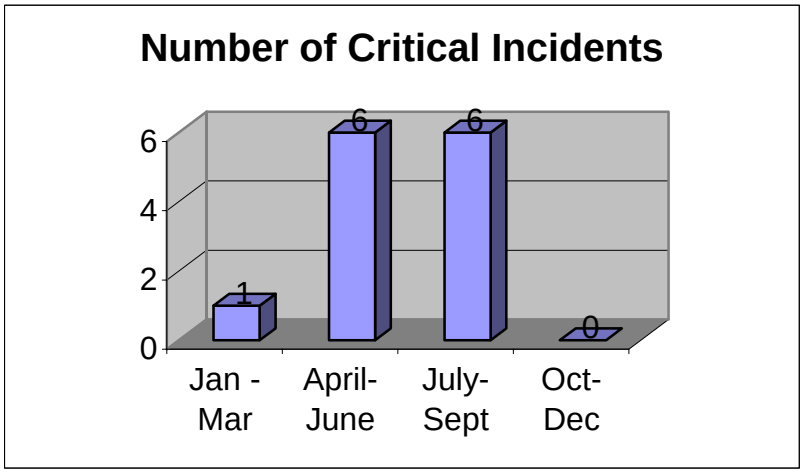
The facility also indicated there were two projects already approved and funded. The projects involved the replacement of the 275 ton centrifugal water chiller and the replacement of emergency generator and switchgear. Both are slated to begin in January 2005.

2. There are systems in place to assure that the environment of care is safe and that consumers are protected.

Through interviews with administrative staff it was learned that the facility relies on all staff to keep a "watchful eye" on the environment for potential hazards and areas of risk. Interviews also revealed that there are a number of mechanisms for assuring that the physical environment is safe. The facility has a safety committee that meets at least quarterly to review data and discuss identified areas of safety management, such as staff injuries and facility event reports. It is the responsibility of Building and Grounds staff to assure that the physical environment is safe, comfortable and maintained. Fire drills are conducted for each shift quarterly. Walk-through inspections of the facility are routinely conducted, which include safety checks of equipment, general maintenance reviews and review of operations of back-up systems. Staff can submit work orders regarding repairs. These are prioritized according to the degree of risk with those that could impact the safety of the patients or staff handled first.

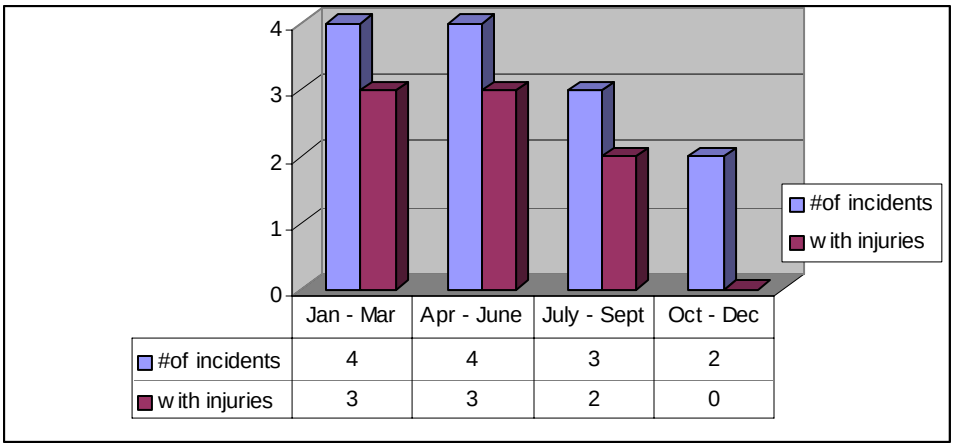
SVMHI has a risk management program. The program description indicates that it is established "to identify, evaluate, and reduce the risks associated with injury to patients, visitors and staff, property loss, or other sources of potential liability to the facility". Data is tracked for trends in a number of key indicators such as patient injuries, falls, patient related staff injuries and incidents of seclusion and restraint usage.

Information provided by the facility indicated that there were 13 critical incidents reported to the Virginia Office of Protection and Advocacy during the 2004 calendar year.



There were 13 incidents of peer to peer aggression during 2004, 8 of which resulted in an injury to one or both of the patients involved.

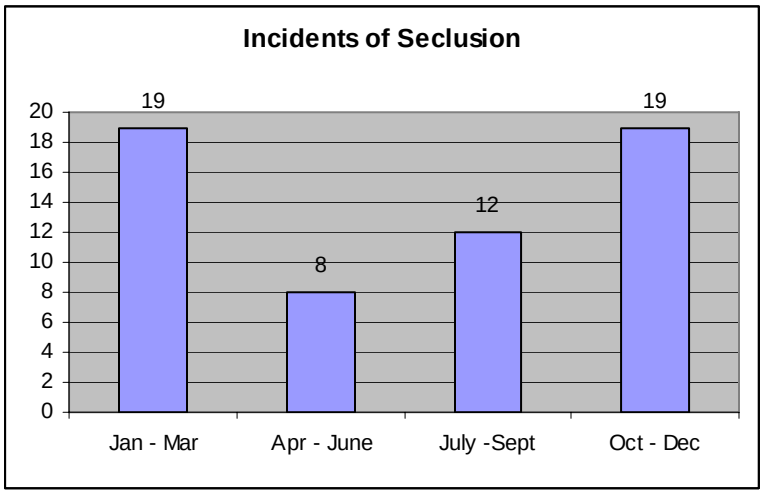
INCIDENTS OF PEER-TO-PEER AGGRESSION (2004)*



	Jan - Mar	Apr - June	July - Sept	Oct - Dec
#of incidents	4	4	3	2
with injuries	3	3	2	0

*Data provided by the facility

During 2004, there were 58 incidents that resulted in the use of seclusion within the facility. There were 3 incidents of physical holds occurring and use of mechanical restraints reported.



All staff are provided training regarding human rights and the reporting of abuse and neglect. There were 3 allegations of abuse and neglect reported in 2004. Of those, 1 was substantiated. The patients made 53 informal complaints and 13 formal complaints during 2004.

During the inspection, a patient alleged that she was verbally abused while she was waiting to obtain her medications. Her allegation of abuse was reported to the facility for

investigation. Follow-up by the OIG revealed that the investigation concluded that the allegation was unfounded.

When asked about the safety and maintenance of the environment of care, 8 of the 9 direct care staff indicated that the facility did a good job in keeping the environment safe. Eight of the 12 consumers interviewed reported they did not feel safe in the environment. Three reasons were given:

- Consumers indicated they did not feel safe because of the negative interactions between staff and the patients.
- They did not feel safe because of the behaviors of some of the other patients.
- They did not feel safe due to the threats that were described as racial in nature.

It is a serious concern to the OIG that consumers do not feel safe at SVMHI.

Quality and Accountability

1. There are systems in place to assure that the services provided from the time of admission to discharge are quality services.

SVMHI has a quality management plan, which is designed to "guide and govern the continuous improvement activities within the facility." During July of each year, the leadership team prioritizes the improvement activities for the upcoming year. Data is collected for most of the identified projects in order to establish baseline information for comparison as the projects progress. Some of the process improvement projects identified for 2005 include: streamlining and improving the treatment planning process, the reduction of the use of seclusion and restraint, efforts to reduce the use of multiple antipsychotic medications and enhancements in the physical environment, such as ground maintenance.

Each clinical department has established performance improvement activities for completion. These include the timeliness of assessment completion, the thoroughness of clinical notes, and the percentage of active treatment activities completed as scheduled.

2. The facility has an accurate understanding of the stakeholders' perceptions regarding the services provided by the facility.

Satisfaction surveys are completed with the consumers. On-going interactions with community providers and representatives from the community services boards allow for open dialogue regarding services and their working relationships. The Southside Behavioral Health Consortium is another avenue through which the facility receives feedback regarding the services provided by the facility.

Interviews with administrative staff indicated that meetings such as the facility directors and medical directors meetings are additional avenues for members of the leadership team to gain feedback about the effectiveness of facility services.

Recommendations

The OIG has the following recommendation regarding the Southern Virginia Mental Health Institute as a result of this inspection. Based on the inspections of all 9 mental health hospitals and mental health institutes, a systemic review report will be issued in the near future that includes additional recommendations for all mental health facilities.

Finding #1: The majority of consumers who were interviewed by OIG staff during the inspection reported that they do not feel safe in the facility environment. The explanations provided by these consumers included:

- Negative interactions between staff and consumers
- Negative or disruptive behaviors of other consumers
- Threats which are described as racial in nature

On several occasions during the inspection, members of the OIG team observed or were told about specific incidents that were representative of all three of these explanations. In addition, the majority of direct care staff who were interviewed by the OIG team had difficulty defining the values that govern the work of the facility and how staff is to relate to consumers.

> **Recommendation #1:** It is recommended that SVMHI assess its organizational culture with the assistance of outside experts to determine why consumers do not feel safe and what steps will be required to correct this problem. Once this assessment is complete, the facility should develop an action plan to implement the identified steps. This plan should also include clarification of the organizational values or principles that guide how the staff is to relate to consumers, establish a training program for both new and existing staff related to these values, and establish an ongoing system for monitoring the extent to which staff's actions are consistent with these values.
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> *DMHMRSAS Response: As part of an on-going process to identify concerns of consumers served at SVMHI, the Executive Director has been holding monthly meetings with consumers; and the Administrator-on-call has regularly made "walk-through" rounds on all shifts (including weekends and holidays). In addition to continuing these activities, SVMHI will establish a special team to hold individual interviews with patients to explore in-depth patients' felt personal safety and to identify incidents involving staff and/or peers that threatened their sense of safety. The team will be comprised of the facility's Human Rights Advocate, at least one consumer from the SVMHI Members Advisory Group (which has one patient representative from each unit), and a member of the Local Human Rights Committee. This team will report their findings to the SVMHI Executive Director and to the state Director of the Office of Human Rights by July 1, 2005. Based on these findings, the facility Administrative Team will develop and implement corrective actions, as indicated.*

Within the next week, SVMHI also will assign the Administrator-on-Call to: 1.) observe staff-to-patient and patient-to-patient interactions; and 2.) speak with staff about the OIG findings as well as explore any incidents about which they are aware that affect patient feelings of safety. These activities will be used as opportunities for impromptu education sessions about facility values, recovery principles, and potential interventions. The Administrator-on-Call will report weekly the findings and issues to the facility Executive Director and members of the Administrative Team at the regularly scheduled Administrative Team meeting by July 1, 2005.

The results of these processes will then help determine milieu and organizational dynamics that may be contributing to consumers' perceived lack of safety. SVMHI is, and has been, committed to ensuring a treatment environment that is safe and free of physical/verbal harm for consumers; and to ensuring that staff interactions and interventions are congruent with the Vision and the Mission of both this facility and the DMHMRSAS. As indicated, SVMHI Administrative Team will take appropriate actions, including reporting any Human Rights violations and investigating any suspected patient abuse or neglect. The Administrative Team, as indicated, will obtain assistance from external experts to develop a plan for improving staff understanding of organizational values, for better equipping them with skills to interact with our consumers within the framework of our values, and for developing a methodology to monitor outcomes of any corrective actions.

Finding #2: Consumer engagement and participation in the psychosocial rehabilitation programming (PSR) sessions observed was very limited. The OIG observed three different PSR groups. One group was cancelled because no consumers showed up. In the second group, 5 of the 10 consumers assigned to the group left in the middle of the session. The third session began late due to a change in staff leadership. As a result, the majority of consumers in all 3 groups failed to experience active treatment and/or skill development.

Recommendation #2: It is recommended that the facility develop a workgroup that involves consumers, clinical staff and direct care staff to review active treatment programming in the facility and develop strategies for improving the effectiveness of the PSR program.

DMHMRSAS Response: SVMHI concurs with the OIG recommendation. As noted in the OIG report, SVMHI staff had recognized a need to improve PSR groups and improve consumer participation in them: and a group of clinical staff and direct care staff, under the leadership of our Trainer and Instructor III, visited sister psychiatric facilities to identify "best practices" in PSR. Based on those visits and the needs of our consumers, a PSR Committee was formed to restructure the PSR program. The PSR Committee currently is comprised of: representatives from unit nurses, Activity Therapists, Social Workers, and Psychologists; the PSR Coordinator. Consumer involvement will be added from the Member Advisory Group to the PSR Committee as the planning for

restructuring the PSR program begins. The PSR Committee will regularly review attendance data and will identify key PSR components and processes needed for improvement. The Committee will report its recommendations to the Administrative Team through the PSR Chairman, who is a standing member of the Team, by July 1, 2005.